Ending Insurance Discrimination:

Fairness and Equality for Americans with Mental Health and Addictive Disorders

Representative Patrick J. Kennedy and Representative Jim Ramstad
May 2, 2007

TABLE OF CONTENTS

Introduction

Mental health and addiction disorders are staggering in their scope. They account for over one-fifth of all lost days of productive life, far more than cardiovascular disease, the runner-up.[1] Approximately 54 million Americans suffer from mental illnesses, and 26 million from addictions, with a large number living with co-occurring mental illnesses and addictions.[2] These diseases touch nearly every family in America, with an impact on nearly every social issue, from education to homelessness to criminal justice to veterans' needs.

Yet most Americans with health insurance face barriers to mental health care and addiction treatment that they do not encounter in accessing other forms of health care. The majority of employer-sponsored health plans include more expensive financial requirements (such as copayments and deductibles), treatment limitations (such as limits on the number of covered outpatient visits or days in the hospital), or excluded diagnoses.[3]

The reasons for this discriminatory approach to health insurance are varied. The mind and body have historically been perceived as separate. Mental illnesses and addictions have historically not been well understood and, because their symptoms are changes in personality and behavior, the diseases have often been perceived as personal failings. It is only in the last few decades, with new technologies like MRIs and PET scans that allow scientists to peer inside the brain and with the revolution in genomics, that the physiological underpinnings of these diseases have been clearly established. Yet policy has not kept up with science.

The History of Mental Health and Addiction Equity Legislation

Federal legislation to equalize mental health benefits with other health care benefits, often called mental health parity, was first introduced in 1992. In 1996, the Mental Health Parity Act of 1996 (MHPA), championed by Senators Paul Wellstone (D-MN) and Pete Domenici (R-NM), was enacted. The MHPA required partial equality by mandating that annual and lifetime dollar limits in coverage for mental health treatment

be no less than those for physical health care. It applied to groups of more than 50 employees.

Legislation to bring full equity to mental health coverage was introduced in the House in every subsequent Congress, but never received consideration in committees or on the Floor, despite bipartisan majority cosponsorship since the 107th Congress. In the 110th Congress, Senators Domenici and Edward Kennedy (D-MA) introduced a new version of the legislation, the Mental Health Parity Act of 2007 (S. 558). The bill, which was the product of negotiations with business and insurance organizations that historically opposed such equity legislation, was marked up in committee on February 14th. A new House version, the Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1424), was introduced by Reps. Patrick Kennedy (D-RI) and Jim Ramstad (R-MN) on March 7, 2007 and currently has 265 cosponsors. Both bills include equality of benefits for addiction treatment as well. Although President Bush has not spoken specifically on either bill, he has articulated support for equalizing mental health benefits in the past.[4]

The Campaign to Insure Mental Health and Addiction Equity

From January through March 2007, Reps. Kennedy and Ramstad participated in informal field hearings around the country as part of the Campaign to Insure Mental Health and Addiction Equity. The hearings solicited information from treatment providers, employers, government and law enforcement officials, scientists, and especially consumers about the impact of mental illness and addiction on individuals' lives and on society, treatment successes and challenges, and the impact of insurance and equity policies on access to care.

Field hearings were conducted in 14 cities nationwide: Providence, RI; Minneapolis; Rockville, MD; Los Angeles; Vancouver, WA; Sacramento; Palo Alto, CA; Denver; Trenton, NJ; Philadelphia; Pittsburgh; New York; Tulsa, OK; and Dallas. Eighteen Members of Congress and two U.S. Senators hosted or participated in hearings.

The field hearings were supported and organized with the help of Mental Health America and NAMI and their local affiliates. Each hearing featured three or more panels of witnesses, including representatives from business and insurance, mental health and medical treatment providers, state and local government officials from all three branches, and mental health and addiction consumers and their families testifying before Members of Congress. Transcripts of these proceedings may be obtained online at www.equitycampaign.net or by contacting the offices of Representatives Kennedy or Ramstad. Those individuals or groups who were unable to provide oral testimony, were able to submit written testimony to be included in the record.

The Campaign was launched with three primary objectives: (1) to provide a forum for testimony by consumers, business, insurance and government leaders who have not had the opportunity to make their voices heard through official Congressional hearings; (2) to examine how various states have been able to negotiate the provision of mental health and addiction health care benefits on behalf of their states' residents; and (3) to inform the revision of federal parity legislation to ensure that it meets the goals of giving every insured fair access to the treatment they might need, regardless of diagnosis.

This report is not exhaustive, and its findings are not based in statistics or formal data gathering. It is, however, a synthesis of the voices of Americans from every walk of life offering their perspectives on how we as a nation can combat the public health crisis represented by untreated and undertreated mental and addiction disorders.

Findings

Enthusiasm for Equalizing Benefits is Extremely High

There was a great deal of variety in the locations and settings of the hearings. Some were in centers of great metropolitan areas, others in suburban enclaves. Some hearings took place at academic medical centers, some in government hearing rooms, and some in the facilities of treatment providers. There were hearings in lower-income and affluent areas. A dominant impression across sites, however, was intense enthusiasm and gratitude for the opportunity to be heard. Most hearings were full to capacity or overflowing. Many included time for audience members to sign up and speak, with long lists of people anxious to share their stories. A number of hearings ran 30, 45, even 60 minutes over their allotted time. People afflicted with mental illnesses and addiction, and those in the field, have so often received short shrift from policymakers that they seemed grateful just for the fact that Members of Congress were coming to hear them out.

Over and over, witnesses described the feelings of betrayal and hopelessness they and their family members experienced upon learning that when they needed it, their insurance was not there. "My insurance premiums are close to $11,000 per year for family coverage," said Kevin Driscoll of Maryland. "And when I needed my insurance for my treatment, it was not there."[5] John Hair, an engineering consultant, echoed that anger from the perspective of an employer: "We fund the coverage, we expect the policies that are sold to us to not be hollow, we expect our government to make sure they are appropriate, just like our government makes sure the structural members that hold this roof above our heads are appropriate."[6]

When people are denied access to the care they need or their family members need, even though they have insurance and pay their premiums like everybody else, they feel like second-class citizens. They see equity legislation as more than a way to reduce barriers to

care. They see it as a civil rights bill that declares that they are entitled to the same opportunities as everyone else.

Access to Treatment is a Life or Death Issue

The field hearings offered stark reminders of the difference access to treatment makes. Over and over the Members of Congress heard about how unchecked mental illnesses and addictions ravaged people of all backgrounds and all walks of life. Sometimes the stories ended in tragedy, as when former Palo Alto mayor Vic Ojakian tearfully talked about his son, a victim of suicide.

Others told stories of personal redemption, of years lost and life reclaimed after receiving treatment. Members met Kevin Hines, a young, gregarious, outgoing man engaged to be married this summer. Kevin jumped from the Golden Gate Bridge in 2002, one of the few to survive. The contrast between Mr. Hines today and the despairing, hopeless individual who climbed over the railing is so stark that it forces us to ask how many others who did not survive the fall similarly could have found contentment and a productive life if only they had treatment.

Even when people are alive, however, the lack of treatment takes their lives, in a manner of speaking. Amy Smith of Denver framed the issue in clear terms. She said that when she meets people she knew 25 years ago, they are stunned she is still alive. She was in and out of jail and emergency rooms, unable to connect with other people, muttering to herself on the street, and unemployed. For 45 years, she says, she was a drain on society. Then she finally got the treatment she needed and now she's a taxpayer, holding down a good job.

Amy Smith lost decades of her life because she didn't get treatment. "I would have been able to pursue my dreams for my life, which were things like driving a car, or holding down a real job, or getting married, or volunteering in the community, any of

those things…. I think my life would have been a lot different if I had had those services a lot earlier."[7]

Recovery is Possible and Treatment Works

That Mr. Hines and Ms. Smith are alive and productive members of their communities makes them living proof of the fundamental truth that treatment does work. Mental health and addiction recovery is attainable and measurable, a fact stated by Glen Andis of the insurance provider Medica: "Evidence has shown at Medica that mental health and addiction treatment works. People improve their health status, their day-to-day functioning, and productivity at work or school. We believe it is essential to provide affordable, accessible, and high-quality behavioral care to achieve positive outcomes."[8]

Scientific breakthroughs have further improved the ability to treat these diseases. For example, Dr. Gerry Clancy, the President of the University of Oklahoma–Tulsa, testified that "if you can treat depression or bipolar disorder up front early with the first episode, you can reduce the number of episodes in half. The average number of bipolar episodes is nine over a lifetime; if you can treat that first episode well, you reduce it down to four."[9] These chronic diseases are now more susceptible to treatment than many other chronic diseases.

And the scientific breakthroughs are only expected to accelerate. Explained Dr. Steve Sharfstein, the CEO of Sheppard Pratt Health System and a past president of the American Psychiatric Association: "A rational psychopharmacology, combined with evidence-based psychotherapy, has transformed the prospects of recovery for such illnesses as schizophrenia, bi-polar illness, major depression, and we'll hear about eating disorder, substance use disorder, attention deficit disorder, and soon, Alzheimer's and autism."[10]

Mental Illnesses and Addiction are Physiological Diseases of the Brain

Mental illnesses and addiction disorders have biological bases that are supported by a vast body of medical literature. Until recent history, scientific and treatment experts

had to speculate on the physiological structures and biological chemicals that contribute to the etiology of these disorders. More recent medical advances have allowed for brain imaging to conclusively map biological and chemical components in the brain that are associated with chronic mental health and addiction disorders. Through this groundbreaking technology, researchers and treatment providers can more decisively diagnose patients, which guide treatment planning more accurately and efficiently.

Given this new level of understanding, old ways of thinking about mind and body distinctly become obviously archaic. Dr. Steven Rasmussen, the Medical Director of Butler Hospital in Providence, RI, and a faculty member at Brown Medical School, showed slides during his testimony of PET scans of healthy and diseased hearts and brains, illustrating the similar visual confirmation of low metabolic rates resulting from disease. He explained that some brain diseases, like Parkinson's disease, affect the motor cortex, the basal ganglia, the sensory cortex, and the thalamus. Other brain diseases, like depression, affect the limbic cortex, hypothalamus, frontal cortex, and hippocampus.[11] Trying to distinguish between regions of the brain deserving of full insurance coverage and those that are not is a fool's errand.

Similarly, Dr. Gerry Clancy, President of the University of Oklahoma-Tulsa, presented a series of brain scans, showing how physiological changes in brain structures and functioning could be detected between individuals with biologically based mental health disorders such as depression, autism and attention deficit disorder and those without. Dr. Clancy noted that "we also have advanced in our understanding of the best forms of treatment for substance abuse and mental disorders. For example, early identification and intervention for clinical depression, post-traumatic stress disorder, autism, and bipolar disorder significantly reduce the severity of those illnesses over the long haul."[12] Dr. Clancy, using the same brain imaging techniques was able to mark the alterations in the brain that represented a return to normalized functioning after treatment.

Stigma Defines the Field of Mental Health and Addiction

Perhaps the most insidious problem that faces policy makers, patient advocates, treatment providers and consumers alike, is the impact of stigma on consideration of mental health and addiction issues. Witnesses told of years lost to disease because they were unable to admit to themselves that they needed treatment. They spoke of being marginalized or blamed for their illnesses, of health professionals not taking their symptoms or diseases seriously. For example, Karen Redden testified at Vancouver, Washington, that a nurse practitioner treating her daughter told her "she needed to lose weight and do something for herself to make herself feel better about herself and, therefore, then she might consider giving her antidepressants."[13]

Members heard testimony about people who were among the two-thirds of Americans with mental illnesses who do not seek treatment. For example, one witness described a conversation with the wife of man who had been a tradesman for nearly fifty years. He spends days that he doesn't get out of bed, she said. "He pulls the shades down in his room and he won't eat for days on end, he misses work, he loses jobs and he gets jobs again because he is in a very high demand trade, and he won't, he refuses to go to mental health and receive help, mental health, he says that is not, I can't do that."[14]

Stigma is not only about shame, but about legitimate fear of reprisals. Lacey Berunen, a veteran of the Iraq War testified in Denver that she took her four-year-old son to the VA when she returned from her first tour of duty "because he had some adjustment disorders having mom come back. And the VA at that point told me, when I was looking for family services, that if they wanted me to have a family, the Air Force would have issued me one…. [F]or a lot of the vets that are coming back, there's amazing amounts of stigma, if you're looking for mental health services, and it will kill your career if you acknowledge that you need them."[15] Mental health and addiction remain dogged by a notion that if one suffers from them, it is a sign of weakness. Until that perception changes, progress remains halting.

Insurance Discrimination is Unaffordable

Those who oppose equalizing mental health and addiction benefits with other health care benefits often argue that though desirable, such a move is too expensive in an era of spiraling health care costs. Testimony at the field hearings repeatedly illustrated that in fact, the opposite is true. Leaving mental health and addiction is too expensive.

The costs of untreated mental illnesses and addiction are felt throughout society. A blue-ribbon task force in Oklahoma estimated that it costs the state $3.2 billion through the prisons, child welfare system, emergency rooms, and other safety nets.

Chiefs of police and state legislators decried the reliance on the criminal justice system as the de facto mental health system of last resort. For example, Sheriff Baca in Los Angeles testified: "I have 2,000 people at any one time in the county jail system who are receiving often for the very first time their mental health treatment."[16] Including addiction-related crime, it can fairly be stated that untreated brain disorders are the primary driver of the criminal justice system. According to research from the National Institute on Drug Addiction, two-thirds of men and women arrested test positive for one of five illegal drugs at the time of arrest.[17] That statistic does not include alcohol, nor all crime committed as part of the drug trade or intended to finance drug purchases. Relying on the jails and prisons to deliver health care makes no sense. Judge Talmadge Jones of the Sacramento County Superior Court expressed the frustration of those presiding over the system: "I want you to picture 50 judges out here because all of them would be here echoing what I'm about to tell you. And that is that our prisons and jails are not the proper place to treat a person with mental illness. It's that simple."[18]

Just as most criminal justice costs are not routinely calculated as part of the cost-benefit equation regarding mental health and addiction treatment costs, so too do our overall health care costs mask the true cost of rationing mental health and addiction treatment. Dr. Victor Pincus, an emergency department head, testified that in his state's only level one trauma center, 80% of trauma admissions are alcohol- and drug-related.[19] Alcohol and drugs are implicated in car accidents, shootings and stabbings, slip-and-falls,

domestic violence incidents, and of course overdoses. Without probing, however, many of these cases do not appear in our health care statistics as being related to drugs or alcohol. As Dr. Arthur Evans testified in Philadelphia: "because of how hospital emergency departments bill, that information isn't recorded. You record a primary diagnosis, admitting diagnosis, and often, the secondary diagnosis of substance abuse isn't captured."[20]

Even excluding these related emergency room visits, discriminatory health insurance policies wind up driving up health care costs. Representatives of seven different insurers confirmed that they support equity legislation because it helps control overall costs. In the words of Jim Purcell, President and CEO of Blue Cross Blue Shield of Rhode Island, allowing limits on access to behavioral health care is "bad medicine, bad law and bad insurance."[21] As Mr. Purcell explained, the costs of office visits are low, but the costs of hospitalizations when people go into crisis is extremely high. Geoff Bartsch of Health Partners in Minneapolis made the same point: "benefits that restrict or deter patients from seeking appropriate care early increase the number of patients who enter the system in a crisis setting…."[22] Thus, in Oklahoma, a state where 26% of its residents have a mental illness or addictive disorder and two-thirds of them are untreated, businesses absorbed $600 million in additional medical costs from depression alone, according to Terri White, Commissioner of the state's Department of Mental Health & Substance Abuse.[23]

These hidden costs extend into the workplace. Dr. Michael Forlenza, Director of Strategic Research for the Jewish Health Care Foundation testified in Pittsburgh that "Most of the costs in mental health is indirect. It is productivity loss. It is not good for those who suffer. It's not good for the economics."[24] As explained by Bob Hulsey from the Williams Companies, a 4000-employee natural gas company based in Tulsa, Oklahoma, when employees develop mental health problems, they often become withdrawn, hostile, and frequently absent. Left unchecked, these changes impact "an individuals' ability to maintain a cooperative and productive presence in the workplace."[25]

The cost of leaving mental illnesses and addictions untreated falls most heavily, however, on the individual. Members of Congress heard powerful testimony from individuals who have lived with disabling mental illnesses and addictions across the country, young and old, from every background and ethnicity. These courageous witnesses shared their personal stories of hardship and lost years in terms that often powerfully evoked the wistful question, what if only they had received treatment sooner. As Amy Smith from Denver put it, "So today I'm a taxpaying citizen with a great job with the Mental Health Association of Colorado, and it took -- but my point is that it took until I was 45 years old to achieve those things, and I think my life would have been a lot different if I had had those services a lot earlier."[26]

The personal toll extends far beyond those suffering from the diseases, of course. The Members of Congress heard a number of parents express their frustration and anguish at fighting the system repeatedly in an attempt to get their children care. They heard from Theresa Landis, a mother of three working two jobs, with insurance, whose ten-year-old son needed counseling and medications that her insurance would not fully cover. While she awaited an eligibility determination for Pennsylvania's S-CHIP program, the boy was jailed after an outburst on the playground.[27] Ivy Silver spent $27,000 out of pocket to get care for her daughter whose eating disorder was so severe her hair was falling out, despite paying her family's health insurance premiums.[28] Of course, these burdens pale next to those of the parents who emotionally testified about losing their children to suicide. Tom O'Clair of New York told of his 12-year-old son, Timothy, wracked by bipolar disorder, hanging himself in his bedroom. Timothy's life is the cost of insurance discrimination.

Steve Winter of Arizona testified at a number of field hearings, traveling to them at his own expense to share his perspective on the costs of insurance discrimination. When he was growing up, he did not realize that his mother had a mental illness. But one morning when he was a teenager, he was eating breakfast and looked down to see his shirt soaked in blood. His mother was standing in front of him with a gun in her hand and said, "Steve, I shot your sister Sally, I shot you, and now I'm going to shoot myself

so we can be in heaven together."[29] The bullet hit his spinal cord and paralyzed him. Mr. Winter, who testified from his wheelchair, held no grudge against his mother, who had gone off her anti-psychotic medications when she changed health plans, but was clear that both he and society paid a steep price because his mother did not receive adequate treatment. "She didn't know what she was doing. And so I'm a victim of that. My bill is going to be like $1.5 million, $2 million over my lifetime."[30]

The Promise of Equality is Too Often not Realized

Most Americans who pay their monthly health insurance premiums believe that if they or their covered family members require treatment, they will be covered. Even when the policy covers them, however, the medical management by health plans frequently present significant barriers to accessing treatment. Consumer witnesses told their personal stories describing their confusion and frustration in attempting to steer through an obstacle course of ambiguous policies that determine what, if any services the recipient will receive. The call for transparency in the decision making process regarding mental health and addiction claims resounded from state to state. Field hearing testimony also highlighted the urgency to address the practice of imposing arbitrary limits and caps on mental health and addiction treatment that other diseases are not subjected to.

Michael Noonan, is the father of a bright, athletic, college-enrolled daughter who suffered from a chemical addiction. After his daughter encountered a series of escalating problems and relapses, her clinician recommended inpatient rehabilitation for her alcohol dependence. He contacted his insurance company and was told that his contract included a benefit for inpatient rehabilitation for chemical dependency with a $200 deductible and 30 day coverage. In spite of confirming these benefits with his managed behavioral health care company, the authorization of his daughters' inpatient care was suspended after only five days of care. Mr. Noonan endured repeated denials, took a home equity loan of $23,000 to pay for treatments while processing appeals, and requested the assistance of his congressional representative in order to secure payment for the treatment of his daughter.[31] His experience was echoed in the testimony of many others, like Xavier Ascanio, whose daughter Samantha was hospitalized for an eating disorder.

"During the inpatient stay, the insurance company doled out pre-approval two or three days at a time. Imagine that hanging over you, both as a parent and as a patient."[32]

In addition to restricting what care will be paid for, managed care companies often require subscribers to remain "in-network" to receive benefits. Yet witnesses told of "phantom networks" that lack sufficient mental health and addiction professionals to adequately manage the amount and scope of the clinical demands many of their subscribers face. Mr. Ascanio from Maryland described the problem trying to find a qualified provider to treat his daughter. "After dealing with a parade of providers who were not helpful, we finally found some who were knowledgeable and could really help. Unfortunately, these providers are not on any insurance company's PPO list."[33]

The result is that consumers are left with a choice between providers without the required specialty or paying exorbitant sums out of pocket. Melinda Lemos-Jackson whose young son was diagnosed with an autism spectrum disorder when he was 3 years of age testified, "Would you go to an internist for a heart condition or would you go to a cardiologist? I have placed the calls to the clinicians, who upon interview, don't meet my son's needs, I have tried some of the in-network clinicians who clearly are not suitable. I've sometimes spoken to highly regarded folks who are actually on the list, only to find out that their practices are closed or they can't take a child like my son at this time, so we get the services our son needs and we learn to bring our checkbook and our Visa. Our health insurance is not accepted."[34]

The aggressive benefits management is frustrating from the provider side as well. Dr. Jennifer Hagman of Denver Children's Hospital estimated that she spends between ten and fifty percent of her time every day negotiating with insurance companies on behalf of her patients.[35] At times the demands for documentation and proof verges into the absurd. Dr. Gerry Clancy from Tulsa described seeking prior authorization for a suicidal patient. Wanting to confirm that this was a serious suicide attempt, the health plan reviewer asked whether the patient had a plan to take his own life. "And I said, That person plans to shoot themselves [sic]. And then the reviewer went farther and said,

Does that person have a gun? And I said yes. And then I could not believe the next question. The next question was does the person have bullets?"[36]

While managed care is a reality throughout health care, and one that affects all specialties, witnesses were convinced that the problems were particularly severe in mental health and addiction. "I am certain that we suffer more from varying interpretations of medical necessity and capricious and arbitrary denials than other specialties in medicine," said Dr. Steven Sharfstein of Sheppard Pratt Health System in Baltimore.[37] David Shern, the President of Mental Health America, voiced a concern echoed throughout the field hearings when he said: "We have work on medical necessity, to make sure that the hope of parity isn't dashed by utilization managers whose primary constraints, oftentimes, has to do with maintaining the profitability of the companies for which they work."[38]

Support for Equity Legislation is Broader than Perceived

Historically, business groups and the insurance industry have strongly opposed legislative efforts to end insurance discrimination against people with mental illnesses and addictions. However, as one witness said, "small business coalitions don't speak for me."[39] The field hearings revealed that in fact there is a great deal of support for equity legislation in those circles if anyone cares to ask.

At various field hearings, as described above, insurance executives expressed their support for the legislation, in total seven in the fourteen field hearings. None opposed legislation. As Rhonda Robinson-Beale, the Chief Medical Officer of United Behavioral Health said unequivocally in answer to Rep. Ramstad's direct question whether her company supported H.R. 1424, "United is committed to the equalization of behavioral health benefits with medical, yes."[40] Representatives of Blue Cross Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, Amica, Health Partners, Buyers Health Care Action Group, and Group Health were equally clear in their support.

A number of business leaders also testified at field hearings, voicing their support for efforts to equalize benefits. They represented large, Fortune 500 manufacturing companies, like PPG in Pittsburgh, down to proprietors of small consulting firms, like John Hair in Tulsa, who said: "I'm a businessman, I'm a small businessman, and I believe that we should have parity for small business owners and employees and I'm prepared to buy that insurance for my employees."[41]

Most of the business witnesses brought practical, hard-nosed common sense to the question of mental health and addiction benefits. Dr. Alberto Colombi from PPG Industries in Pittsburgh compared the quiet reaction to an employee's suicide with the strong response to a workplace injury, and questioned the implicit judgments about the value of the two employees' lives.[42] Several of the witnesses spoke of the advantages their companies derived in terms of worker recruitment and retention. Employers who look at the data support equity legislation for one reason: "it's been an asset to our bottom line."[43]

Conclusions

1. Parity is Critical as a Statement of Equality

Individuals with mental illnesses and addictions are frequently held responsible for their illnesses as a result of archaic but deep-seated perceptions of culpability or weakness. The brain scan and genomic science refutes those old stereotypes, yet even in the minds of many with the diseases, they live on. The etiology of many chronic diseases is a combination of genetics, environment, and individual responsibility. A person born with a genetic predisposition to heart disease who nonetheless consumes great quantities of saturated fats is undoubtedly making a heart attack more likely. Yet society does not put up obstacles to cardiac care for that person.

Proponents of insurance equity for mental health and addiction treatment have frequently been told that it is simply too expensive. While the data unequivocally refute that contention (see Conclusion 2), the argument itself is a reflection of the ongoing stigma and misinformation about the nature of mental health and addiction. If the issue were simply cost, a health plan could bring costs down significantly by putting restrictions on coverage of diabetes, for example. Naturally no plan does so, and Congress and the American people would rightly react swiftly and furiously if one tried.

If a person pays their health insurance premiums, she should know that her health care will be paid for when she gets sick, regardless of what specific diagnosis she receives or treatment her provider recommends. Yet individuals with mental illnesses and addictions are routinely told that they must sacrifice care that is often the difference between life and death in order to hold costs down for everyone else. In essence, health insurance is for them an elaborate bait-and-switch. They pay the premiums like everyone else, but when they get sick, the insurance is not there.

In this context, mental health equity legislation is crucial not simply for the access to treatment it provides, but for the message it sends. Our current discriminatory health

care system reinforces the stereotypes that deter people from seeking care and diminish the seriousness with which health care professionals and policymakers take mental health and addiction. And the discrimination tells individuals with mental illnesses that they are not valued by society. The Supreme Court made this point succinctly in *Brown v. Board of Education* when discussing segregated education, clearly a much more blatant and insidious form of discrimination. But after hearing so many individuals with mental illnesses and addictions recount not just their frustration and hopelessness but their self-doubts and self-loathing in many cases, one must conclude that, in the words of the *Brown* Court, any legally sanctioned discrimination "generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone."[44] The promise of equal opportunity enshrined in our Declaration of Independence and Constitution are our country's touchstone; mental health and addiction equity legislation brings us closer to that ideal.

2. Equity is Cost-Effective

Any discussion of the costs of equalizing benefits must acknowledge the unfairness of the premise. Individuals suffering from other diagnoses never have to justify whether their treatment will save other people money or not. Nevertheless, when one considers the incredible cost driver that untreated mental illnesses and addictions represent to society at large, the notion that equalizing benefits is too expensive becomes laughable. At a public policy level, there can be no debate. Consider simply one result of undertreating these diseases: more than half of all inmates have mental health problems, according to the Department of Justice,[45] and drug-related crime costs us $107 billion per year.[46] Thus, police chiefs from big cities like Los Angles and Dallas, smaller cities like Providence, and suburbs like Arvada, CO agreed that it makes much more sense, in the words of Chief Dean Esserman of Providence, to "invest not arrest."

A better question may be whether equity is cost-effective for the businesses that pay most health care costs in the private sector. Even here, however, both the data and the field hearing testimony clearly indicate that it is. There is no need to speculate. In

2000, the Federal Employees Health Benefits Program (FEHBP) implemented full mental health and addiction equality for its nearly 9 million members. All plans participating in the FEHBP have been required since that time to cover any mental health condition (including addictions) included in the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) for which there is clinically proven treatment. Naturally, plans may continue to manage benefits in their customary manner, but any mental health and addiction treatment must be offered on the same terms as other physical health care.

One of the most comprehensive cost studies of mental health equity ever conducted concluded that the implementation of the policy did not raise mental health costs for the FEHBP. The authors concluded: "Overall, the parity policy was implemented as intended with little or no significant adverse impact on access, spending, or quality, while providing users of MH/SA [mental health and substance abuse] care improved financial protection in most instances."[47] This finding mirrors the results of nearly every study of state parity laws, which have almost uniformly found no or incidental costs associated with mental health equity.[48] There is no need to estimate or guess what the impact of equity legislation would be; we know from experience that it will not measurably increase costs.

Moreover, the FEHBP study looked only at mental health costs. There is every reason to believe that improving treatment of mental health and addiction will lower other costs to business. Indeed, this is the unequivocal position of a number of business and insurance leaders who testified. Jim Purcell, the President and CEO of Blue Cross Blue Shield Rhode Island; Rick Calhoun from CB Richard Ellis in Denver; Dr. Alberto Colombi of PPG in Pittsburgh, Bob Hulsey of the Williams Companies in Tulsa, and others each expressed in their own words the sentiment of Mr. Hulsey: "I absolutely believe that [offering equal mental health benefits] helps the business."[49]

These business leaders have looked at the data and recognized that untreated mental illnesses and addictions cost employers in numerous ways. Other health care costs are higher, whether as a result of preventable emergency room visits – as much as 80% of

trauma admissions are alcohol- and drug-related[50]-- or uncontrolled chronic physical diseases. Depressed patients, for example, are three times as likely as non-depressed patients to be non-compliant with their medical treatment regimen.[51] Consequently, health care utilization and costs are up to twice as high among diabetes and heart disease patients with co-morbid depression, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses.[52] According to Ms. Monte of BankRI, "Total medical expenditures were four to five times higher for employees with mental disorders compared to medical expenditures for employees with no mental illness."[53]

Indeed, there may be no greater indication that paying for better mental health benefits is cost-effective than the fact that some health plans may be doing it even when not contractually required to. Dr. Jennifer Hagman, director of the eating disorders treatment program at the Denver Children's Hospital, said that when managed behavioral health companies refuse to pay for outpatient care after an eating disorder patient is stabilized, either because eating disorders are excluded or a benefit is exhausted, the health plan responsible for medical benefits (but not the mental health benefits) is sometimes choosing to pay nonetheless for the care to prevent the patient from returning to the hospital.[54]

Lost productivity is likely an even greater cost of leaving mental illnesses and addictions untreated than other health costs. By one study, depressed workers lose 5.6 hrs per week of productive work time vs. 1.5 hours per week for non-depressed workers. This lost productivity costs employers $31 billion per year for depression alone. Most of the lost productivity takes the form of presenteeism and is largely invisible to employers.[55] Productivity losses related to alcohol use have been estimated at $135 billion annually.[56] Small wonder, then, that Mr. Calhoun of CB Richard Ellis called offering coverage equity a "no-brainer."[57]

3. Legislation Must be Carefully Crafted to Limit Loopholes

The purpose of mental health and addiction equity legislation is straightforward: to equalize mental health and addiction benefits with other health care benefits. As in all things, however, the devil is in the details. In 1996, health plans responded to the new requirement that annual and lifetime limits be equalized by imposing treatment limits to ensure that new, higher mental health lifetime and annual limits could never be reached.[58] One conclusion from past experience and the testimony at the field hearings is that health plans, as a rule, will seek every opportunity to avoid paying claims. The legislation will not succeed in equalizing benefits if it leaves room for interpretation by health plans.

This conclusion has particular application in at least three areas of mental health and addiction equity legislation. First, how is the requirement of equality structured? As a general proposition, any equity legislation requires equality between mental health and addiction benefits and medical and surgical benefits. But what is the basis of comparison between mental health and addiction on the one hand, and medical and surgical on the other? The bill should take that answer out of the hands of health plans to as great an extent as possible. The Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1424) specifies that the basis of comparison is to be broad categories of inpatient and outpatient care, separately for in- and out-of-network.

A second question is who defines what a mental illness is. The purpose of the legislation is to end discrimination on the basis of diagnosis. Leaving plans the latitude to define what diseases are covered by a mental health benefit leaves them the latitude to discriminate by diagnosis. Members of Congress have heard testimony from parents of consumers who were shocked to learn that their insurance did not in fact cover their children's disease when she got sick. Passing equity legislation should end that phenomenon, but if plans are able to discriminate by diagnosis, there will continue to be parents who discover that even among mental illnesses, some are less favored and thus less covered. Health plans will retain the ability to make case-by-case medical necessity determinations, but they should not be able to arbitrarily decide that conditions recognized by the medical establishment are not worthy of coverage.

A third potential loophole is in how legislation applies the equity requirements to out-of-network coverage. If a health plan covers physical health care out-of-network, but only covers mental health and addiction in-network, it is not offering equal coverage. Thus, requiring equality between out-of-network physical and mental health coverage is inadequate if a plan is allowed simply to shut down its out-of-network mental health and addiction coverage. As PPOs have come to dominate the health insurance market, this issue has particular resonance. Out-of-network coverage is considered by many providers and consumers to be critical in mental health and, particularly, addiction treatment. One reason is that critical provider shortages often render networks inadequate. Xavier Ascanio of Maryland described calling practice after practice futilely searching for a provider who took his insurance with expertise in adolescent girls' eating disorders.[59] Especially for addiction treatment, going out of state, away from one's former patterns and acquaintances is often a necessary component of recovery.

Finally, because regulations are always imperfect, and because the federal government is often slower to act than states, this conclusion also counsels in favor of a preemption regime that allows states to extend protections beyond those afforded by federal law. The last eleven years provide a practical example of why setting a federal floor, rather than a ceiling, makes sense. In 1996, when the Mental Health Parity Act became law, only 8 states had similar laws on the books. Today, in the eleven years that Congress has been unable to close down the massive loopholes left in the 1996 Act, an additional 38 states have stepped into the breach.

More recently, states like Pennsylvania and Washington have enacted legislation to clamp down on abusive managed care practices while Congress has been unable to act. If in the future, lawmakers discover that certain practices are violating the spirit and intent of mental health and addiction equity legislation, states are far more likely to act quickly in response than the federal government, and we should encourage them to do so.

4. Strong Enforcement is Vital

Any regulation, however well written, is only as strong as its enforcement. Witnesses in a number of states with equity laws reported that state laws are often honored in the breach. Equity legislation must have mechanisms to ensure that health plans comply with its requirements and to enable consumers to register complaints. The 1996 Act (and both the Senate and House bills this Congress) amend ERISA and the Health Insurance Portability and Accountability Act, each of which have their own enforcement provisions.

In 1997, a tax penalty provision was added to the Internal Revenue Code to penalize plans that did not comply with the terms of the 1996 Act. That IRC provision must be amended to extend the tax penalty provisions to any new equity law passed. The House bill, H.R. 1424 does so; the Senate bill, S. 558 does not, for reasons of committee jurisdiction. Because the bills contain no private right of action for aggrieved consumers to recover damages, federal enforcement is dependent on action by federal agencies which may be over-extended or not interested. It is therefore also important that federal law not pre-empt the ability of states to enforce their own equity requirements on the health insurance carriers they regulate.

5. Equalizing Benefits is Only Part of the Solution

The testimony from both consumers and providers reveals barriers to care that extend beyond those written into policies. The challenges include onerous and repetitive preauthorization requirements, opaque medical necessity criteria, phantom networks, and arbitrary denials of coverage reversed on appeal that seem to reflect a policy intended to create additional hoops for beneficiaries. These managed care abuses may be exacerbated in the mental health and addiction treatment field but are endemic to managed care in general. Correcting them is probably beyond the scope of legislation intended to equalize benefits.

To the extent that the purpose of equity legislation is to improve access to mental health and addiction care, however, there is a need to explore separately possible legislative responses to these managed care problems. At the very least, in the context of equity legislation, Congress should ensure that it does not stand in the way of states seeking to place limits on abusive managed care practices.

The supply of qualified mental health and addiction treatment professionals is another significant barrier to care that will not be solved by legislation to equalize benefits. This is a major problem that has been recognized by expert panels such as the President's New Freedom Commission and the Institute of Medicine committee that examined the quality of mental health and addiction treatment. The problem is particularly pronounced for providers who serve children and in rural areas – the American Academy of Child and Adolescent Psychiatry has two members in the entire state of Wyoming – but the problem exists throughout the field. One partial solution would be for plans to better reimburse mental health providers, as suggested by Oklahoma State Rep. Kris Steele.[60] In many cases, mental health professionals are reimbursed significantly worse than their counterparts in other specialties. "Fee parity," as implemented by Blue Cross Blue Shield of RI,[61] would help stanch the steady stream of providers who are opting to cease taking insurance altogether. The federal government should also undertake efforts such as loan forgiveness and other strategies to lure young people into the field.

Still, while passage of equity legislation will not immediately tear down all barriers to care, it is a the critical first piece of the solution. Not only does it at least reduce the barriers on paper, as discussed above, it helps undermine the stereotypes and stigma that contribute to other obstacles to care.

Endnotes

[1] Murray, CJL and Lopez AD, eds. "The Global Burden of Disease and Injury Series, Volume 1: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.
[2] Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 1999; NAADAC Fact Sheet at http://naadac.org/documents/display.php?DocumentID=98, citing the Substance Abuse and Mental Health Services Administration.
[3] General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, May 2000.
[4] Milbank, Dana. "Bush Backs Mental Health Parity; President Mixes Pitch for Health Care with Fundraising." Washington Post, April 30, 2002, p. A04.
[5] Rockville Field Hearing, p. 29.
[6] Tulsa Field Hearing, p. 37-38.
[7] Denver Field Hearing, p. 48.
[8] Minneapolis Field Hearing, p. 66.
[9] Tulsa Field Hearing, p. 88-89.
[10] Rockville Field Hearing, p. 31.
[11] Providence Field Hearing, p. 50-51.
[12] Tulsa Field Hearing, p. 78.
[13] Vancouver Field Hearing, p. 33-34.
[14] Providence Field Hearing, p. 112-13.
[15] Denver Field Hearing, p. 63.
[16] Los Angeles Field Hearing, p. 43.
[17] U.S. Department of Justice, National Institute on Justice, Annual Report of Adult and Juvenile Arrestees, 1997.
[18] Sacramento Field Hearing, p. 71.
[19] Providence Field Hearing, p. 54.
[20] Philadelphia Field Hearing, p. 25.
[21] Providence Field Hearing, p. 75.
[22] Minneapolis Field Hearing, p. 86.
[23] Tulsa Field Hearing, p. 59.
[24] Pittsburgh Field Hearing, p. 52-53.
[25] Tulsa Field Hearing, p. 111-12.
[26] Denver Field Hearing, p. 67.
[27] Philadelphia Field Hearing, p. 58.
[28] Philadelphia Field Hearing, p. 54.
[29] Dallas Field Hearing, p. 55.
[30] Pittsburgh Field Hearing, p. 56.
[31] Providence Field Hearing, p. 64-70.
[32] Rockville Field Hearing, p. 35.
[33] Rockville Field Hearing, p. 36.
[34] Providence Field Hearing, p. 100.
[35] Denver Field Hearing, p. 52.
[36] Tulsa Field Hearing, p. 85-86.
[37] Rockville Field Hearing, p. 45.
[38] Rockville Field Hearing, p. 76-77.
[39] Tulsa Field Hearing, p. 38.
[40] Providence Field Hearing, p. 95.
[41] Tulsa Field Hearing, p. 38-39.
[42] Pittsburgh Field Hearing, p. 61-62.
[43] Testimony of Maureen Underwood, Dallas Field Hearing, p. 59.
[44] Brown v. Board of Education, 347 U.S. 483 (1954).

[45] James, Doris and Glaze, Lauren E. "Mental Health Problems of Prison and Jail Inmates," Bureau of Justice Statistics, September 2006.
[46] Office of National Drug Control Policy, "The Economic Costs of Drug Abuse in the United States 1992-2002" (2004).
[47] HHS, *Evaluation of Parity in the Federal Employees Health Benefits (FEHB) Program: Final Report*, 12/31/04.
[48] For example, see SAMHSA's study from Vermont and studies of Medica and Minnesota Department of Commerce.
[49] Tulsa Field Hearing, p. 118-19.
[50] Testimony of Dr. Victor Pincus, Providence Field Hearing, p. 29.
[51] Ziegelstein RC. "Depression in patients recovering from a myocardial infarction." *JAMA*, 2001; 286(13): 1621-1627.
[52] National Center on Quality Assurance. "State of Healthcare 2004: Industry Trends and Analysis." Washington, DC: NCQA; 2004; Lustman PJ. Clouse RE. "Depression in diabetic patients: The relationship between mood and glycemic control." J. of Diabetes and Its Complications, 2005; 19: 113-122.
[53] Providence Field Hearing, p. 54.
[54] Denver Field Hearing, p. 53.
[55] Stewart et al., "Cost of Lost Productive Work Time Among US Workers With Depression." JAMA, 2003.
[56] Horgan, C., et al, *Substance Abuse: The Nation's Number One Health Problem*. Schneider Institute for Health Policy, Brandeis University, 2001.
[57] Denver Field Hearing, p. 61.
[58] General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, May 2000.
[59] Rockville Field Hearing, p. 37.
[60] Tulsa Field Hearing, p. 64.
[61] Testimony of Jim Purcell, Providence Field Hearing, p. 76.